

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00405

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Calvert 412</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drumkirk</u>		c. LENGTH OF STAY IN 1b <u>MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Eva Mae</u> First <u>Brady</u> Middle Last				<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>11</u> Year <u>1959</u>			
<b>5. SEX</b> <u>7</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb 27, 1914</u>	<b>9. AGE</b> (In years last birthday) <u>44</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>			
<b>13. FATHER'S NAME</b> <u>Thomas H. Crumiger</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Wetzig</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>319-12-4189</u>		<b>17. INFORMANT</b> Address: <u>John Brady Drumkirk MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause last. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Body found in bed by husband about 11:50 PM</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Probably murder</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>11</u> o. m. <u>10</u> p. m.		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. City or town</b> <u>Drumkirk</u>		<b>20g. County</b> <u>Calvert</u>		<b>20h. State</b> <u>MD</u>			
<b>21. I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>H. W. Ward</u>			<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>H. W. Ward</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>11/11/59</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Jan. 14 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Lothian, Maryland</u>		<b>22e. State</b> <u>MD</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witching Funeral Home (Wings) MD</u>			<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 14 '59</u>				
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Evans</u>			<b>24c. State</b> <u>MD</u>				

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Signature]*

*Found in bed by  
Robert J. [unclear]*

PC

111

*1/10/11*

00406

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

423

## CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH- COUNTY <u>County Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, Maryland.</u>	
TOWN <u>Huntingtown</u>		TOWN <u>Huntingtown, Maryland.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home; Huntingtown, Md.</u>		STREET ADDRESS <u>same as above</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Preston</u> (Middle) <u>-</u> (Last) <u>Brown</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>c</u>	7. SINGLE, (MARRIED) WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4/12/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer and Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>
13. FATHER'S NAME <u>Gilbert Henson</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Mattie Kyler-Huntingtown, Md.</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral accident.Antecedent cause(s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Hypertensive C.V.R. disease

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from 5-10, 1955, to 31 Jan, 1959, that I last saw the deceasedalive on 31 Jan, 1959, and that death occurred at 11 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB 4 '59

Arthur L. Huns

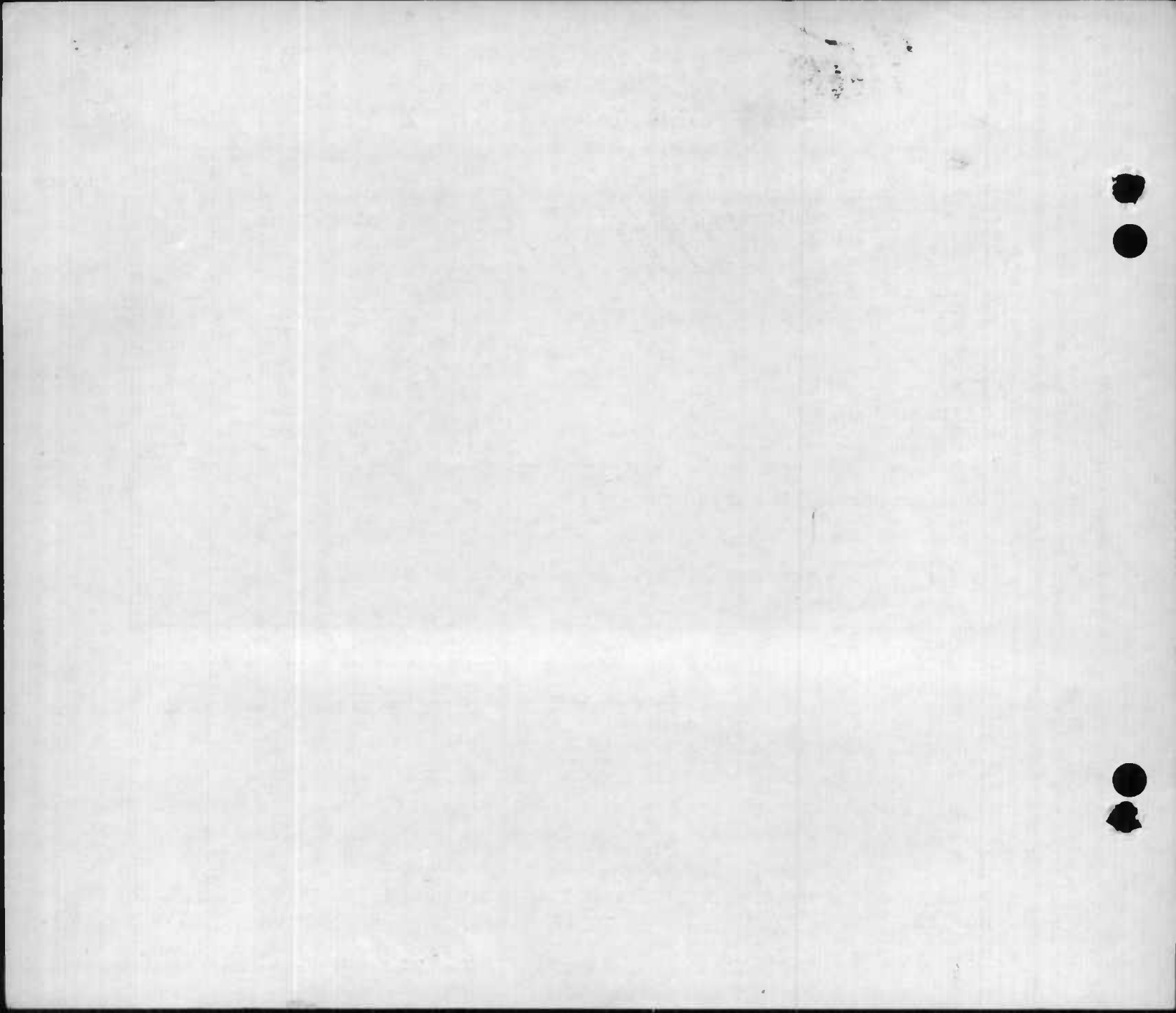
(M.P.)

LEROY E. BERRY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co Hospital</u>				d. STREET ADDRESS <u>Ches. Beach Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loyce</u> Middle <u>G.</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/6/1908</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Conn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Butler</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Balch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WN#</u>		17. INFORMANT <u>Burton Butler</u> Address <u>Chesapeake Beach, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism</u>							
977X DUE TO (b) <u>Fracturing of both arms</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Self inflicted</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found bleeding in bathroom &amp; home 11/14/59 at 5 AM</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Self inflicted</u>				20b. DESCRIBE HOW INJURY OCCURRED, giving nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>			
20c. TIME OF INJURY Month <u>11</u> Day <u>12</u> Year <u>59</u> a. m. <u>5</u> p. m. <u>5</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Ches. Beach</u> (County) <u>Cabot</u> (State) <u>MD</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>				(State) <u>Va</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Wackness &amp; Son - Mutual, Ind</u>				24a. REC'D BY REGISTRAR <u>Arthur L. House</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	
				DATE <u>JAN 16 59</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Witness		14. Signature of Physician		15. Signature of Nurse	
16. Signature of Undertaker		17. Signature of Funeral Home		18. Signature of Cemetery	
19. Signature of Burial Society		20. Signature of Religious Society		21. Signature of Other	
22. Signature of Other		23. Signature of Other		24. Signature of Other	
25. Signature of Other		26. Signature of Other		27. Signature of Other	
28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other	
34. Signature of Other		35. Signature of Other		36. Signature of Other	
37. Signature of Other		38. Signature of Other		39. Signature of Other	
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97. Signature of Other		98. Signature of Other		99. Signature of Other	
100. Signature of Other		101. Signature of Other		102. Signature of Other	

RECEIVED  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
JAN 10 1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

415

## CERTIFICATE OF DEATH

00408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings</b>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Curtis</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1900</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Wallace</b>				14. MOTHER'S MAIDEN NAME <b>Aire Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Savonia Jacks, Owings, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) <b>Cerebral sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 23, 1958</b> to <b>Jan 1, 1959</b> , that I last saw the deceased alive on <b>Jan 1, 1959</b> , and that death occurred at <b>St Leonard, Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>St Leonard</b> <b>1/3/59</b>							
ACTUAL SIGNATURE <b>Dr. Roberto de Villarreal</b>				M.D. <b>St Leonard, Md.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Jan 4, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>		22d. LOCATION (City, town, or county) (State) <b>Sundeland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sewell</b>				ADDRESS <b>Prince Fred, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1

DATE OF DEATH

PLACE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY IN 1b <u>Port Republic Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co Hospital</u>		d. STREET ADDRESS <u>Port Republic Md</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie L Dorsey</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/59</u>
9. AGE (In years (with birthday)) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Anne</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md</u>	
13. FATHER'S NAME <u>Alexander Laocelle</u>		14. MOTHER'S MAIDEN NAME <u>Ann Hedrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Benny Laocelle, Port Republic</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>900.0</u> DUE TO <u>Fractured legs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Ws</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell down stairs at home</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10/2</u> p. m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Anne</u>		20f. City or town <u>Port Republic Calvert Md</u>	
20g. County <u>Calvert</u>		20h. State <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H W Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 10-1959</u>		22b. DATE THEREOF <u>Jan 10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) <u>Port Republic - Calvert Co. Md</u>	
22e. ADDRESS <u>  </u>		22f. State <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A G. Hardness &amp; Son - Mount Airy, Md</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>		DATE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REPLACEMENT: Film 238 - 1-28-59 ams

417

## CERTIFICATE OF DEATH

00410

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>P.</u> Last <u>Gibson</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Huntingtown, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Gibson</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Mary Sheekells</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-38-6419</u>		17. INFORMANT <u>Klora Gibson - Huntingtown - Cabot Co., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary of Plaque</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>14 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 1957, to <u>January</u> , 1959, that I last saw the deceased alive on <u>Jan 23</u> , 1959, and that death occurred at <u>100 M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		ADDRESS (Street, city or town, state) <u>—</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		DATE SIGNED <u>1/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 25, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown - Cabot Co - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Hackman &amp; Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10-11-19

10-11-19

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF JUDGE [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF REGISTRAR [REDACTED]	
19. SIGNATURE OF [REDACTED]		20. SIGNATURE OF [REDACTED]		21. SIGNATURE OF [REDACTED]	
22. SIGNATURE OF [REDACTED]		23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]	
25. SIGNATURE OF [REDACTED]		26. SIGNATURE OF [REDACTED]		27. SIGNATURE OF [REDACTED]	
28. SIGNATURE OF [REDACTED]		29. SIGNATURE OF [REDACTED]		30. SIGNATURE OF [REDACTED]	
31. SIGNATURE OF [REDACTED]		32. SIGNATURE OF [REDACTED]		33. SIGNATURE OF [REDACTED]	
34. SIGNATURE OF [REDACTED]		35. SIGNATURE OF [REDACTED]		36. SIGNATURE OF [REDACTED]	
37. SIGNATURE OF [REDACTED]		38. SIGNATURE OF [REDACTED]		39. SIGNATURE OF [REDACTED]	
40. SIGNATURE OF [REDACTED]		41. SIGNATURE OF [REDACTED]		42. SIGNATURE OF [REDACTED]	
43. SIGNATURE OF [REDACTED]		44. SIGNATURE OF [REDACTED]		45. SIGNATURE OF [REDACTED]	
46. SIGNATURE OF [REDACTED]		47. SIGNATURE OF [REDACTED]		48. SIGNATURE OF [REDACTED]	
49. SIGNATURE OF [REDACTED]		50. SIGNATURE OF [REDACTED]		51. SIGNATURE OF [REDACTED]	
52. SIGNATURE OF [REDACTED]		53. SIGNATURE OF [REDACTED]		54. SIGNATURE OF [REDACTED]	
55. SIGNATURE OF [REDACTED]		56. SIGNATURE OF [REDACTED]		57. SIGNATURE OF [REDACTED]	
58. SIGNATURE OF [REDACTED]		59. SIGNATURE OF [REDACTED]		60. SIGNATURE OF [REDACTED]	
61. SIGNATURE OF [REDACTED]		62. SIGNATURE OF [REDACTED]		63. SIGNATURE OF [REDACTED]	
64. SIGNATURE OF [REDACTED]		65. SIGNATURE OF [REDACTED]		66. SIGNATURE OF [REDACTED]	
67. SIGNATURE OF [REDACTED]		68. SIGNATURE OF [REDACTED]		69. SIGNATURE OF [REDACTED]	
70. SIGNATURE OF [REDACTED]		71. SIGNATURE OF [REDACTED]		72. SIGNATURE OF [REDACTED]	
73. SIGNATURE OF [REDACTED]		74. SIGNATURE OF [REDACTED]		75. SIGNATURE OF [REDACTED]	
76. SIGNATURE OF [REDACTED]		77. SIGNATURE OF [REDACTED]		78. SIGNATURE OF [REDACTED]	
79. SIGNATURE OF [REDACTED]		80. SIGNATURE OF [REDACTED]		81. SIGNATURE OF [REDACTED]	
82. SIGNATURE OF [REDACTED]		83. SIGNATURE OF [REDACTED]		84. SIGNATURE OF [REDACTED]	
85. SIGNATURE OF [REDACTED]		86. SIGNATURE OF [REDACTED]		87. SIGNATURE OF [REDACTED]	
88. SIGNATURE OF [REDACTED]		89. SIGNATURE OF [REDACTED]		90. SIGNATURE OF [REDACTED]	
91. SIGNATURE OF [REDACTED]		92. SIGNATURE OF [REDACTED]		93. SIGNATURE OF [REDACTED]	
94. SIGNATURE OF [REDACTED]		95. SIGNATURE OF [REDACTED]		96. SIGNATURE OF [REDACTED]	
97. SIGNATURE OF [REDACTED]		98. SIGNATURE OF [REDACTED]		99. SIGNATURE OF [REDACTED]	
100. SIGNATURE OF [REDACTED]		101. SIGNATURE OF [REDACTED]		102. SIGNATURE OF [REDACTED]	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Cabot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Paris</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Joseph</i> First <i>Holland</i> Middle <i>Holland</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>29</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>?</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Holland</i>		14. MOTHER'S MAIDEN NAME <i>Louise Holland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Edward Holland, Owings, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular renal disease</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>5 yrs</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been sick without a doctor for 4 wks</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>2-1, 59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Edmonson</i>		22d. LOCATION (City, town, or county) (State) <i>Sunderland MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell</i>		24a. REC'D BY REGISTRAR <i>Dr. Fred. M. D.</i>	
		24b. REGISTRAR'S SIGNATURE <i>1/29/59</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







419

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. AGE OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>E.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 59</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/02</u>	9. AGE (In years last birthday) <u>56</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>David Jones</u>			14. MOTHER'S MAIDEN NAME <u>Maude E. Jordan</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-12-5134</u>		17. INFORMANT Address <u>Margaret K. Hines, Chesapeake Beach Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V.R. disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>58</u> , to <u>1/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/24</u> , 19 <u>59</u> , and that death occurred at <u>5:45AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Maryland</u> DATE SIGNED <u>1/25/59</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				PHYSICIAN'S NAME (Type) <u>Dr. George J. Weems</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-59</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Mt Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Nr Owings Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

So, what?

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H. Beach</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H. Beach</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Johny</u> Middle <u>M.</u> Last <u>Kirin</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9, 1886</u>	9. AGE (In years - what birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel mill worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yugoslavia</u>		11. BIRTH PLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kirin 167-03-6119</u>				14. MOTHER'S MAIDEN NAME <u>Dobrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>X 167-03-6119</u>		17. INFORMANT <u>John P. Kirin</u>		Address <u>H. Beach</u>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic vascular Renal disease</u> <u>442x</u> DUE TO (b) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead 1220 P.M. 11/7/59</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krana</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



421

## CERTIFICATE OF DEATH

00414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cabret</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>			
c. LENGTH OF STAY IN 1b <i>5 days</i>				d. STREET ADDRESS <i>—</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Fred</i> Middle <i>K.</i> Last <i>Lankford</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>7</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 12, 1901</i>	9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipes Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fred K. Lankford</i>				14. MOTHER'S MAIDEN NAME <i>Olivia Gausley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-16-3045</i>		17. INFORMANT <i>Amy Lankford - Solomons, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> <i>593x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive end</i> DUE TO (c) <i>nephritis</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 5</i> 19 <i>59</i> , to <i>Jan 7</i> 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 7</i> 19 <i>59</i> , and that death occurred at <i>2:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R de Villareal</i> M.D.				ADDRESS (Street, city or town, state) <i>5th Avenue</i> DATE SIGNED <i>1/7/59</i>			
PHYSICIAN'S NAME (Type) <i>R de VILLAREAL</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 10, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Solomons Catholic Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Solomons - Cabret Co - Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness &amp; Son - Mutual, Ind.</i> ADDRESS				24a. REC'D BY REGISTRAR <i>DATE JAN 12 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





422

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barstow</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>		d. STREET ADDRESS <u>Barstow</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Hall Lyons</u>		4. DATE OF DEATH <u>Jan. 18, 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>54</u> Days <u>18</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Felia Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Samuel L. Lyons - Barstow, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 17, 1959</u> to <u>Jan 18, 1959</u> , that I last saw the deceased alive on <u>Jan 17, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D.		ADDRESS (Street, city or town, state) <u>Prince Frederick</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		DATE SIGNED <u>Jan 21 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 20, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Miranda Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Cabret Co. - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 21 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1880"]		PLACE OF DEATH [Faint text, possibly "Boston, Mass."]	
OCCUPATION [Faint text, possibly "Clerk"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Jan 20, 1925"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "J. J. ..."]		SIGNATURE OF CLERK [Faint text, possibly "J. J. ..."]		SIGNATURE OF DECEASED [Faint text, possibly "J. J. ..."]	
SIGNATURE OF WITNESS [Faint text, possibly "J. J. ..."]		SIGNATURE OF DECEASED [Faint text, possibly "J. J. ..."]		SIGNATURE OF DECEASED [Faint text, possibly "J. J. ..."]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

## 423 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash D.C. 16X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Nursing Home</i>		d. STREET ADDRESS <i>6263 Titchie Rd</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>NEZ MARIE MORTON</i>		4. DATE OF DEATH Month <i>1</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1888-?</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U S A</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Calvert Nursing Home Prince Frederick Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYPERTENSION</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis (Hypertension)</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 18, 1958</i> , to <i>Jan 10, 1959</i> , that I last saw the deceased alive on <i>Jan 7, 1959</i> , and that death occurred at <i>7:15 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Prince Frederick 1/10/59</i>			
ACTUAL SIGNATURE <i>PAUL C. JETT</i>		M.D. <i>Prince Frederick</i>	
PHYSICIAN'S NAME (Type) <i>PAUL C. JETT</i>		<i>PRINCE FREDERICK</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Maryland.</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME IN FULL  
JAMES B. ALLEN  
JAMES B. ALLEN  
JAMES B. ALLEN

DATE OF BIRTH  
1912

PLACE OF BIRTH  
BALTIMORE, MD.

DATE OF DEATH  
1912

PLACE OF DEATH  
BALTIMORE, MD.

CAUSE OF DEATH  
HEART DISEASE

DATE OF BURIAL  
1912

PLACE OF BURIAL  
BALTIMORE, MD.

NAME OF FUNERAL HOME  
BALTIMORE, MD.

NAME OF MINISTER  
BALTIMORE, MD.

NAME OF CLERGYMAN  
BALTIMORE, MD.

NAME OF CLERGYMAN  
BALTIMORE, MD.

NAME OF CLERGYMAN  
BALTIMORE, MD.

424

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>				d. STREET ADDRESS <u>02X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>William</u> Last <u>Scrivener</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-1871</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retiree</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retiree</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William B. Scrivener</u>				14. MOTHER'S MAIDEN NAME <u>Sally Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Annie U. Scrivener</u> Address <u>Lothian Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arteriosclerosis (Nephrosclerosis)</u> DUE TO (c) <u>Dehydrated Myocardium</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>59</u> , to <u>1/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George C. Jett</u> M.D. <u>PRINCE FREDERICK</u> PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u> <u>Prince Frederick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>Translandung Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benard J. Jett</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>JAN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Jett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MADE BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DEATH OF  
JAMES C. MILES  
JAMES C. MILES

Name of deceased		JAMES C. MILES	
Age		45	
Sex		Male	
Race		White	
Date of death		April 15, 1945	
Time of death		10:30 AM	
Place of death		Home	
Cause of death		Heart disease	
Disease or injury		Coronary artery disease	
Duration of illness		Several months	
Occupation		Engineer	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		April 16, 1945	
Place of registration		Baltimore, Md.	



425

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bartow</u>		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Rebecca</u> Last <u>Stafford</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR # UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabret Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augusta Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Annie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Frank Stafford - Bartow, Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure (Coronary thrombosis)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Cerebrospinal arterio-sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 21, 1959</u> , to <u>Jan 24, 1959</u> , that I last saw the deceased alive on <u>Jan 24, 1959</u> , and that death occurred at <u>9:51</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R de Villarreale</u>				ADDRESS (Street, city or town, state) <u>St Leonard</u>		DATE SIGNED <u>1/24/59</u>	
PHYSICIAN'S NAME (Type) <u>R de VILLARREAL</u>				DATE <u>1/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bartow - Cabret Co - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>O. G. Harkness &amp; Son - Bartow, Ind</u>				24a. REC'D BY REGISTRAR <u>Jan 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1911

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>		<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>		<p>8. Signature of registrar: _____</p>	
<p>9. Date of registration: _____</p>		<p>10. Office of registration: _____</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00419

426

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>	
c. LENGTH OF STAY IN lb <u>1 years.</u>		d. STREET ADDRESS <u>08x.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First Middle Last <u>TURNER</u>		4. DATE OF DEATH <u>Jan. 15</u> 19 <u>59</u> . Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry A. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Marquerite A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John T. Mudd</u> Address <u>Bryantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate?</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 19, 1958</u> to <u>Jan 15, 1959</u> , that I last saw the deceased alive on <u>Jan 14, 1959</u> , and that death occurred at <u>6 p. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jetti</u> M.D.		ADDRESS (Street, city or town, state) <u>Prince Frederick</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETTI</u>		<u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial January 18, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 20 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fourn</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-10

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

# CERTIFICATE OF DEATH

100-10

100-10

<p>1. Name of deceased (Print name and last name)          JAMES EARL RAY</p>		<p>2. Sex          Male</p>	
<p>3. Date of birth          May 19, 1928</p>		<p>4. Place of birth          Jackson, Mississippi</p>	
<p>5. Date of death          May 14, 1968</p>		<p>6. Place of death          Jackson, Mississippi</p>	
<p>7. Cause of death (List all causes, beginning with the immediate cause)          1. Gunshot wound, self-inflicted          2. Suicide          3. Mental disease</p>		<p>8. Manner of death (Check one)  <input checked="" type="checkbox"/> Natural    <input type="checkbox"/> Accidental    <input type="checkbox"/> Suicide    <input type="checkbox"/> Homicide</p>	
<p>9. Signature of physician or other qualified person          JAMES EARL RAY</p>		<p>10. Signature of registrar          JAMES EARL RAY</p>	
<p>11. Signature of medical examiner          JAMES EARL RAY</p>		<p>12. Signature of coroner          JAMES EARL RAY</p>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Solomons</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabot County Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>W. Watson</u> Last <u></u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 27, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dental Profession</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Watson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mrs Frank Galloway - Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Ruptured Abdominal Aneurysm</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cholesterol</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-4</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 16</u> , 19 <u>59</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Page Jett</u> M.D. <u>Prince Frederick</u> PHYSICIAN'S NAME (Type) <u>PAUL C. JETT</u> <u>PRINCE FREDERICK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G. A. Harkness &amp; Son - Mount, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1237

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		65		10/15/1873		BALTIMORE		MD		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
10/25/1938		BALTIMORE		MD		MD		USA		10/27/1938		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		PERMANENT RESIDENCE		TEMPORARY RESIDENCE		OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CORONARY THROMBOSIS		NATURAL		BALTIMORE, MD		BALTIMORE, MD		CLERK		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
10/25/1938		BALTIMORE		MD		MD		USA		10/25/1938		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
10/25/1938		BALTIMORE		MD		MD		USA		10/25/1938		BALTIMORE		MD	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00421
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paris</b>			c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dunkirk</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>1</b>					
3. NAME OF DECEASED (Type or print) <b>Philip ODELL</b> First <b>WILSON</b> Last					4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>19 59</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>OCT. 28,</b>		9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>Roland Aber Wilson</b>					14. MOTHER'S MAIDEN NAME <b>Sadie Young, Dunkirk Md.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>					16. SOCIAL SECURITY NO. <b>579-01-8635</b>		17. INFORMANT <b>Sarah Wilson Dunkirk, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Exposure</b> <b>932.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Alcoholism</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Exposure to cold</b>										INTERVAL BETWEEN ONSET AND DEATH
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>1/18/19 59</b> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Paris Calvert Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>1/20/59</b>		
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-22,59</b>		22b. DATE THEREOF <b>Coopers</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Halls Creek, Md</b>		22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.E. Sewell Prince Fred, Md</b>					24a. REC'D BY REGISTRAR <b>DATE JAN 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>			

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

Medical Examiner

OFFICE OF THE MEDICAL EXAMINER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Race		Religion		Marital Status	
Occupation		Education		Social Status		Cause of Death	
Manner of Death		Contributing Factors		Postmortem Examination		Disposition of Body	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
Date of Certificate		Time of Certificate		Place of Certificate		Office of Certificate	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

429 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00422

Item 9 Film 6237 1-19-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelina</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelina</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Wm</i> First <i>Billy</i> Middle <i>Young</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>E</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/20 1873</i>
9. AGE (In years and months) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months <i>4</i> Days <i>1</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Public Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Rd</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert Young</i>		14. MOTHER'S MAIDEN NAME <i>Saline Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm Young, Adelina Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 782.4 DUE TO (b) <i>Age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been sick all day</i>		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-8-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Carroll</i>		22d. LOCATION (City, town, or county) (State) <i>Bearston Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. F. Sewell</i>		ADDRESS <i>Brunce Fredm</i>	
24a. REC'D BY REGISTRAR <i>JAN 12 59</i>		24b. REGISTRAR'S SIGNATURE <i>Calvin E. Knecht</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CITY _____	
COUNTY _____		STATE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF SIGNATURE _____		OFFICIAL SEAL _____	

THE STATE DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND